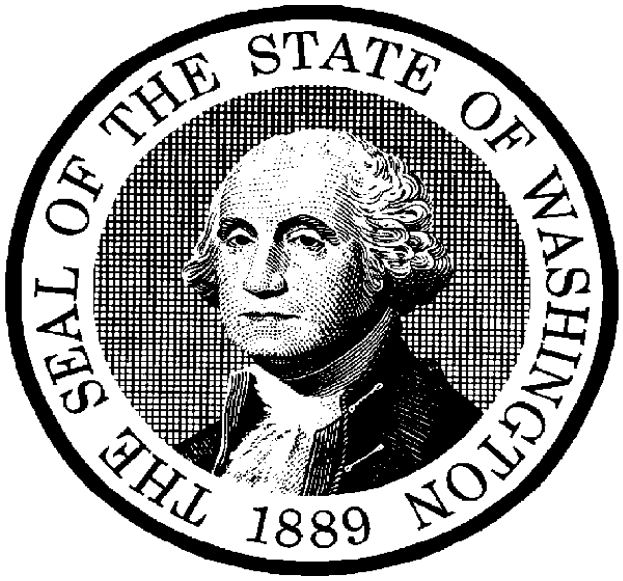
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Mental Health Division

and

Medical Assistance Administration



Involuntary Treatment Act (ITA) Transportation

Billing Instructions

October 2000

About this publication

This publication supersedes all previous MAA Transportation of Involuntary Patients Billing Instructions and Numbered Memorandum 00-39 MAA.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
October 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

Applying for a provider

Call:
Provider Enrollment Unit
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1026
(360) 725-1032
(360) 725-1033

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9245
Olympia WA 98507-9245

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Call:
Provider Relations Unit (PRU)
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Write/call:
Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Definitions

This section defines terms and acronyms used throughout these billing instructions.

Accept Assignment – When a medical provider agrees to accept Medicare payment for a given service or equipment as payment in full, except for specific deductible and coinsurance amounts for which the client is responsible

Authorization - An official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Client – For the purpose of these billing instructions, "consumer" will be used in the place of "client."

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office(s) (CSO) - An office of the department which administers social and health services at the community level. (WAC 388-500-0005)

Consumer - Persons, couples, or families who are eligible to receive, or are receiving, clinical, coordinative, or support services. (WAC 275-57-020)

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

County Designated Mental Health Professional (CD-MHP) – A person who, under the guidelines specified by the Involuntary Treatment Act (ITA), detains an individual and assesses that individual's level of need for transportation according to established county procedures. Following the assessment, the CD-MHP has the individual transported by local police, sheriff, or ambulance.

Department - The state Department of Social and Health Services. (DSHS)

Emergency Medical Condition – The sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Department of Health – The Washington state department in charge of preserving public health, monitoring health care costs, maintaining minimal standards for quality in health care delivery, and generally overseeing and planning the state's activities as they relate to the health of its citizenry. (WAC 246-01-001)

Hospital – An institution licensed as a hospital by the department of health. (WAC 388-500-0005)

Intermediary - A private organization (usually an insurance company) that has been designated by the Health Care Financing Administration (HCFA) to process claims and make payments to hospitals for Medicare Part A (hospital insurance). For Medicare Part B, these organizations are called *carriers*.

Involuntary Treatment Act (ITA) - For adults: chapter 71.05 RCW; also see chapter 275-55 WAC. For juveniles: chapter 71.34 RCW; and chapter 275-54 WAC.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005

Outpatient mental health services - An array of mental health services provided to mental health consumers who meet medical necessity criteria. Outpatient mental health services are provided in the consumer's community through the Regional Support Network.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Physician - A doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed. (WAC 388-500-0005)

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Regional Support Network - A county authority or group of county authorities recognized by the secretary of DSHS that enter into joint operating agreements to contract with the secretary of DSHS to implement a locally managed community mental health program. (Refer to WAC 275-57-010)

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Residence - A client's [consumer's] home or place of living not including a hospital, skilled nursing facility, or residential facility with skilled nursing services available. (WAC 388-551-2010)

Revised Code of Washington (RCW) - Washington State laws.

State Unique Procedure Code(s) – MAA procedure code(s) used for a specific service(s) where there is not a Current Procedural Terminology (CPT), Health Care Financing Administration's Common Procedure Coding System (HCPCS), or Current Dental Terminology (CDT) code available or appropriate.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

ITA Transportation

What is the purpose of Involuntary Treatment Act (ITA) Transportation?

The Involuntary Treatment Act (ITA), Chapter 71.05 RCW, provides for the involuntary detention of individuals who are assessed by a County Designated Mental Health Professional (CD-MHP) as being:

- A danger to themselves;
- A danger to others; or
- Gravely disabled.

Each county develops and maintains the ITA transportation process and has a procedure that CD-MHPs follow. The CD-MHP is authorized to approve the level of transportation needed. When the CD-MHP detains an individual, the CD-MHP assesses the level of need for transportation. As a result of this assessment, the CD-MHP follows established county procedures and chooses one of the following modes of transportation:

- **The local police or sheriff**

  The CD-MHP contacts local law enforcement to request transport for involuntarily detained consumers who need a high security/safety level of supervision; or

- **Ambulance**

  The CD-MHP contacts an ambulance provider to request transport for involuntarily detained consumers when:

  ✓ The police department will not transport; or
  ✓ The involuntary consumer is medically fragile.

  When ambulance services are provided, ambulance providers must bill the Medical Assistance Administration (MAA) using the procedures outlined in this document to receive reimbursement.

Client Eligibility

Verification of Eligible Involuntarily Detained Consumers

- The county or Regional Support Network (RSN) must verify all ITA claims using the ITA Patient Claim Information form (13-628x)* to ensure that the billing is for services to a consumer involuntarily detained under Chapter 71.05 RCW. This verification can take place at the time of service or after services have been provided and must show the following:

  - ✓ Date of initial ITA detention;
  - ✓ Date of 72-hour hearing;
  - ✓ Date of conversion to voluntary consumer status (if appropriate);
  - ✓ Date of release or transfer.

- After verification that the individual is an eligible involuntarily detained consumer, the provider of service sends the HCFA-1500 claim form with the ITA Patient Claim Information form attached to:

  Medical Assistance Administration
  Division of Program Support
  P.O. Box 9245
  Olympia, WA 98504-9245

- MAA receives and processes claims, but ALL claims are funded through Mental Health Division (MHD).

* **A sample of this form is attached to this billing instruction. You can obtain copies of this form by mailing a request to the DSHS Warehouse at PO Box 45816 (Mailstop 45816), Olympia, WA 98504-5816 or faxing a request to (360) 664-0597.**

Coverage

What is covered?

- The Mental Health Division (MHD) covers transportation for ITA consumers when provided from:

  - ✓ The site of the initial detention;
  - ✓ A court hearing; or
  - ✓ An evaluation and treatment facility.

- MHD covers transportation for ITA consumers when provided to:

  - ✓ An evaluation and treatment facility;
  - ✓ A less restrictive alternative setting; or
  - ✓ A court hearing.

What is not covered?

MHD does not cover non-ITA transportation (e.g., for voluntary mental health consumers or those who need transportation to and from outpatient services). For information regarding non-ITA transportation, please refer to the following MAA publications:

- For emergent situations, the Ground/Air Ambulance Medical Transportation Billing Instructions, dated July 2000; and

- For non-emergent situations, the General Information Booklet, dated September 2000.

☞ **Note:** See Important Contacts section for ordering information.

Provider Requirements

Who may provide ITA transportation and when?

Transportation of Involuntary Treatment Act (ITA) consumers may be provided by an organization designated by the local mental health center and/or RSN under the following conditions:

- Transportation may be provided from:

  - ✓ The site of initial detention;
  - ✓ A court hearing; or
  - ✓ An evaluation and treatment facility; and

- Transportation may be provided to:

  - ✓ An evaluation and treatment facility;
  - ✓ A less restrictive alternative setting; or
  - ✓ A court hearing.

Vehicle standards and maintenance

- Vehicles and equipment must be maintained in good working order and may be inspected by DSHS staff on request. The following equipment must be installed on each vehicle transporting physically restricted consumers:

  - ✓ The vehicle must be equipped so consumers are unable to interfere with the driver's operation of the vehicle;
  - ✓ Door(s) adjacent to a consumer must be secured from being opened from the inside of the vehicle when the consumer is not accompanied by an escort person other than the driver;
  - ✓ American Red Cross first aid box or equivalent;
  - ✓ Fire extinguisher;
  - ✓ Flares, or other warning devices;
  - ✓ Flashlight; and
  - ✓ Traction devices or tire chains when required by the Department of Transportation.

Driver Requirements

Each designated organization must include the following criteria in its driver selection process:

- Verify that the driver has a valid state driver's license;
- Verify that the driver has not had any major moving traffic violations for the past three years and has not been involved in any at-fault accidents within the past two years; and
- Verify that the driver is physically capable of safely handling consumers and capable of safely driving the vehicles. It is recommended that verification of these abilities be in the form of a written medical statement, or, if not available, some other form of credible verification.

Driver Training

Drivers must be completely familiar with their job and be able to use all accessory equipment in a safe manner. A driver-training program includes:

- First aid training including current cardio-pulmonary resuscitation (CPR) certification; and
- The operation and use of all equipment associated with the job.

Fee Schedule

Procedure Code	Description	Maximum Allowable
S0215	Non emergency transportation; mileage, per mile	$2.98/mile
T2001	Non emergency transportation; patient attendant/escort	$6.36/trip

- The mileage rate is only for those miles that the involuntarily detained consumer is on-board the vehicle (loaded mileage). MAA does not allow any additional charges beyond the rate per mile allowance.
- MAA reimburses for transportation services at a provider's usual and customary rate or MAA's maximum allowable per mile, whichever is less, for each eligible involuntarily detained consumer.
- MAA considers its payment as payment in full. MAA allows no additional charge to the involuntarily detained consumer.

☞ **Note:** Form 13-628 must be completed and attached to the HCFA-1500 claim form.

☞ **Note:** In box 19 of the HCFA-1500 claim form, indicate "ITA."

Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the internal claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? (WAC 388-502-0020)

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including (as appropriate), but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for at least six years from the date of service</u> or more if required by federal or state law or regulation.**

☞ **Note:** A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD **DESCRIPTION**

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each MAA client. This information is obtained from the client's current monthly Medical Assistance IDentification (MAID) card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).
  For example:

  ✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSQ.
  ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE Q.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source**: When applicable. Enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for local use**: Required. Enter "ITA."

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 04, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. Enter **99.**

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate CPT or HCFA Common Procedure Coding System (HCPCs) or state unique procedure code from the fee schedule in these billing instructions for the services being billed.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code or V90.0. When code V90.0 is used, written justification noting condition requiring level of service is necessary (enter in *field 21*).

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

PIN: Enter the seven-digit number assigned to you by MAA here.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

Must attach ITA Form 13-628

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): S-040256SMITHA

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LEWIS PETER B

3. PATIENT'S BIRTH DATE MM DD YY: 04 02 56 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 60 BURGESS AVE #201

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: UPTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V68.9 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 15 03	10 15 03	99		S0215		V68.9	1490	5				
2 10 15 03	10 15 03	99		T2001		V68.9	636	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 2126

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 2126

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN SHERIFFS DEPARTMENT
22 1ST AVE
ANYWHERE, WA 98000 360-555-1111

PIN# 9000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Form 13-628

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